

Cafeteria Plan Advisors, Inc.
420 Washington St., Suite 100
Braintree, MA 02184
781-848-9848 (Phone)

www.CPA125.com

781-848-8477 (Fax)

AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

SIGNED FORM MUST BE RETURNED BY:

New Hire: Within 30 days of Employment

Open Enrollment: Submit by May 24, 2016

Return form to the Human Resource Department, Room 123

Name: _____

Employer: **Town of Walpole**

Address: _____

Division: _____

Town Plan

Year:

7/1/16 - 6/30/17

School Plan

Year:

9/1/16 - 8/31/17

(expenses must be incurred between these dates)

Home Phone: _____

E-Mail Address: _____

SSN: _____

I am a: Town Employee

☐

Deductions will be taken weekly.

I am a: School Employee

☐

Deductions will be taken over 21 pay periods
September 2016 through June 2017 payroll check

Benefits Selected:

☐ FSA Medical/Dental Care Account (**\$2,550 maximum**)
(Medical/Dental plan includes Debit Card)

I elect to Contribute \$ _____ for the Plan Year.

☐ FSA Dependent Care Account/Daycare (**\$5,000 maximum**)
(Requires Dependent Care Certification form - available online)

I elect to Contribute \$ _____ for the Plan Year.

Direct Deposit Information: (REQUIRED, unless already on file with CPA, Inc./For manual claims & Dependent Care Claims)

I hereby authorize Cafeteria Plan Advisors, Inc. to deposit my claim reimbursements directly to my bank. I also authorize drafts to adjust any over deposits that were credited to my account. I will contact CPA, Inc. immediately with any bank information changes.

Name of Bank: _____ [] Checking [] Savings

Account Number: _____ Routing Number (9 digits): _____

I hereby authorized a salary reduction for the amount(s) shown above. I understand that:

- * This election cannot be revoked or changed during the plan year without a qualifying event as defined in the IRS regulations.
- * Dependents must qualify under regulations set forth by the IRS.
- * Services must be consistent with allowable medical deductions under the IRS Code.
- * Failure to return this signed form to CPA, Inc. by the deadline will result in termination from the plan.

Signature: _____

Date: _____

Notice: Effective 1/1/2011, over the counter items (Medicines) are no longer an eligible FSA expense per the Health Care Reform Act.